Advance Healthcare Planning in Healthcare

A spiritual duty and a soulful one

Fr. Calin Tamiian MA, BCC
Reflection …

“Spirituality is not just about religion, or church attendance, or fidelity to one or other legal requirement. Spirituality is understood to be an innate wisdom of the human heart that enlivens a zest for life, a search for meaning and purpose, a love for all that is good and beautiful, a passion to create a better world, a sensitivity to the life energy (God, if you will) that permeates the entire cosmos.”

Diarmud O’Murchu from “Our world in transition”.
Spirituality vs. Religion

- Spirituality has become a subject in its own right, requiring a quality of research based on a multi-disciplinary analysis. Spirituality has broken away from religion and outstrips it on several fronts.

- Religion tends to be defined in terms of creed, ritual and moral code. Spirituality heavily emphasizes a more authentic quality of relating among diverse peoples, cultures and aspects of the created universe.
Role of Spirituality in Healthcare

- Patient Advocacy
- Diagnosis Awareness
- Peace and calm
- Increase patient satisfaction
- Reduces length of stay
- Mission integration
- Patient education
- …..
A Century of Change

Early 1900s:
- life expectancy: 46 years
- people died quickly (accidents, infectious disease)
- medicine focused on caring, comfort

Today:
- increased to 79 years (2010)
- only 10% die suddenly; 90% live with chronic illness
- science and technology raise difficult decisions
Only 25% of Americans ...
Why plan?

- When health professionals are uncertain, default = treat.
- If haven’t spoken with patient, hard to predict wishes.

50% of people won’t be able to participate in their own end-of-life decisions.
Patients and families come to us with different Beliefs, Behaviors, Values and Expectations
Personal Reflection Survey
Advance care planning process

- Consider your wishes for care.
- Select your agent/decisionmaker.
- Discuss wishes with agent, loved ones, MD.
- Complete advance directive document.
- Give copies to agent, loved ones, MD.
- Periodically review and make any changes.
What is an Advance HealthCare Directive?

- A way to make health care wishes known if unable to communicate.
- Allows a person to do either or both of the following:
  - Appoint a power of attorney for health care (a healthcare agent).
  - State instructions for future health care decisions.
Which document do I use?

- no single form for California
- nothing magical about a form
- several to choose from
  - can get from hospital social services or chaplaincy
  - download from the Coalition for Compassionate Care of California (www.coalitionccc.org)
  - download for any state from Caring Connections (www.caringinfo.org)
What makes a document legal?

- your signature and date
- the signatures of 2 witnesses (or notary)
- if you are in a skilled nursing facility, the signature of the patient advocate or ombudsman
Who do I choose as my agent?

- person you trust to make decisions you want
  - familiar with your personal values
  - willing and able to make decisions
- doesn’t need to be a family member
- tell others in the family who you chose, why
- select alternate
What kind of instructions?

- place of death
- MD preference
- accepting or refusing life-sustaining treatment
- quality of life considerations
- organ/tissue donation instructions
Pre-Hospital DNR

DNR
(Do Not Resuscitate)

- Can only use if choosing DNR
- Only applies to resuscitation
- Only honored outside the hospital
POLST
POLST

- P – Physician
- O – Orders
- L – Life
- S – Sustaining
- T – Treatment

POLST complements an Advance Directives and is not intended to replace that document.
Why POLST?

- Patient wishes often are not known.
  - The Advance HealthCare Directive (AHCD) may not be accessible.
  - Wishes may not be clearly defined in AHCD.
  - The AHCD is not a physician order.

- Allows healthcare professionals to know and honor your wishes for care.
What is POLST?

- A physician order recognized throughout the medical system.
- Portable document that transfers with the patient.
- Brightly colored, standardized form for entire state of CA.
National POLST Paradigm Programs

As of January 2014

www.polst.org
## POLST vs. Advance Health Care Directive

<table>
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<tr>
<th>POLST</th>
<th>AHCD</th>
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<tbody>
<tr>
<td>• For seriously ill/frail, at any age</td>
<td>• For anyone 18 and older</td>
</tr>
<tr>
<td>• Physician orders for <em>medical</em> treatment</td>
<td>• General instructions for treatment</td>
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<tr>
<td>• Can be signed by decisionmaker</td>
<td>• Appoints decisionmaker</td>
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Where Does POLST Fit In?

Advance Care Planning Continuum

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness \(\text{(at any age)}\)

Complete a POLST Form

Treatment Wishes Honored
What do I do with the documents?

- Give copy to your agents.

- Make copies for other loved ones.

- Take one to your doctor to discuss; ask to have included in your medical record.

- Keep a copy yourself; if you go to the hospital, take it with you.

- Photocopies are just as valid as the original.
Transitions in Care

• As disease progresses, discuss with patients/families:
  ✷ Current health status
  ✷ How health has changed
  ✷ How disease may progress
  ✷ Possible ongoing decline
  ✷ What they hope for
Challenges?

- Fears/Emotions
  - Religious concerns
    - Ethics
- Political agendas
  - SB 128
- Lack of time or significance
Activities

- Meaningful Conversation
- Create Awareness
- Celebrate National Healthcare Decisions Day - April 16
- Empower Faith Community Nursing
- Play Go Wish with staff & pt.
- Complete your AHCD
- Teach a friend about POLST or AHCD
- Collaborate with your Palliative Care Team
Advance Care Planning ... a process

Reflect
Select agent
Discuss
Complete AHCD
Complete POLST
Distribute
Review/Update

peace of mind
Resources

- Coalition for Compassionate Care of California - www.coalitionccc.org
- California Hospital Association - www.calhospital.org
- Visit www.caPOLST.org
- Visit www.caringinfo.org
- Visit www.americanbar.org
- Visit www.caringadvocates.org
- Visit www.gowish.org
- Visit www.nhdd.org
Questions?

Developed by Center for Healthcare Decisions
Permission given to use for educational purposes.
For information, contact www.chcd.org
Myrtle’s Story

The Benefits of Advance Care Planning
Myrtle’s Story

Several years ago, when Myrtle Anderson’s husband died, she was troubled that he seemed to suffer so needlessly before his death. He spent the last six weeks of his life in the intensive care unit, on a ventilator.

She wanted to make sure that she would not face a similar situation.
Myrtle’s Story

So Myrtle wrote a Living Will.

She stated that she didn’t want “extraordinary measures” taken to keep her alive if she were terminally ill or permanently unconscious.

She locked it in her desk with her will and other important papers.
Myrtle’s Story

Recently, when Myrtle’s nephew Tom could not reach her by phone, he went to check up on her. He found her lying on the floor, confused and unable to speak.

He called 911 and she was admitted to the hospital. At the hospital, the physician’s evaluation revealed a stroke.
Myrtle’s Story

When asked if she has an Advance HealthCare Directive (AHCD), Tom says that he doesn’t know -- she had not said anything to him about it.
Myrtle’s Story

Once she is stabilized, the physician calls her daughter, Carol, in North Carolina to discuss Myrtle’s current and future treatment.

Carol and her mother had not spoken for several years. Carol says that she has no idea what her mother would want and that she has her own problems to worry about and hangs up.
Myrtle’s Story

When Myrtle’s primary care physician is contacted, he says that he and Myrtle never discussed her wishes if she became critically ill.
Myrtle’s Story

Myrtle’s condition improved.

Though she wasn’t able to speak clearly and had some difficulty swallowing, she was no longer confused.

Her nephew, Tom, helped arrange for her transfer to a skilled nursing facility (SNF) for speech rehabilitation.
Myrtle’s Story

When she was asked at SNF admission if she had an AHCD, to everyone’s surprise, she nodded her head emphatically, “yes.”

Tom agreed to look for the AHCD at her home. Tom found Myrtle’s Living Will.
Myrtle’s Story

The physician caring for Myrtle in the SNF asked her if she meant for the document to direct her care. Myrtle nodded, “yes.”

Though there was no agent/decisionmaker designated, the doctor said she would place a copy of the Living Will in Myrtle’s record and make note of it.
Myrtle’s Story

The doctor also told Myrtle and Tom about the POLST form (Physician Orders for Life-Sustaining Treatment).

She said, “POLST is a physician order documenting the patient’s wishes for healthcare.”
Myrtle’s Story

The physician asked Myrtle about CPR and Myrtle shook her head “No” emphatically.

The physician recognized and documented that Myrtle had decisionmaking capacity and checked “Do Not Attempt Resuscitation” on her POLST.
Myrtle’s Story

Myrtle chose “Comfort-Focused Treatment” in Section B of the POLST

She chose “No Artificial Nutrition” in Section C of the POLST
Myrtle’s Story

Myrtle’s rehabilitation progressed well, and she regained her ability to speak and swallow.

Myrtle requested assistance in completing a new AHCD in order to appoint her nephew Tom as her legal agent/decisionmaker.
Myrtle’s Story

She also said that she wanted Tom to make all her decisions for her, starting immediately, and told the physician not to bother her daughter.

The POLST form went home with Myrtle when she was discharged.
Myrtle’s Story

Myrtle’s daughter, Carol, came to visit.

The visit was pleasant and Myrtle did not want to “stir things up” by telling Carol about the decisions she had made.

While Carol was visiting, however, Myrtle collapsed and Carol called 911.
Myrtle’s Story

The emergency medical personnel found Myrtle’s bright pink POLST on her refrigerator and transported it to the hospital with her, along with her AHCD.

Myrtle’s POLST form was in a plastic cover, with her AHCD slipped in behind the POLST.
In the emergency room, EMS gave the POLST to the staff. They noted that Myrtle chose “Do Not Attempt Resuscitation” (DNR) and “Comfort-Focused Treatment.”

Carol wanted everything done to save her mother. She did not understand why the doctors were following the POLST form to guide her care.
Myrtle’s Story

Due to the severity of the stroke, Myrtle died. She was comfortable during the dying process.

Tom was asked about tissue donation. Following Myrtle’s wishes, Tom consented to donation of any tissue that might be useful.
Myrtle’s Story

The AHCD and POLST helped Myrtle to receive the type of care that she wanted during serious illness.
Summary:
Advance Care Planning

- Think about wishes for care
- Talk with loved ones/physician about wishes
- Select agent/decisionmaker
- Complete AHCD and POLST
- Keep AHCD and POLST in well-known location
- Periodically review and update if needed
AHCD Documents

- No single form in California
- AHCD forms available at no cost from most hospitals or download at: www.coalitionccc.org
- Legal forms for all US states available from Caring Connections at: www.caringinfo.org
The POLST form is available from: www.caPOLST.org